HOUSE CALL
intercommunity hospital

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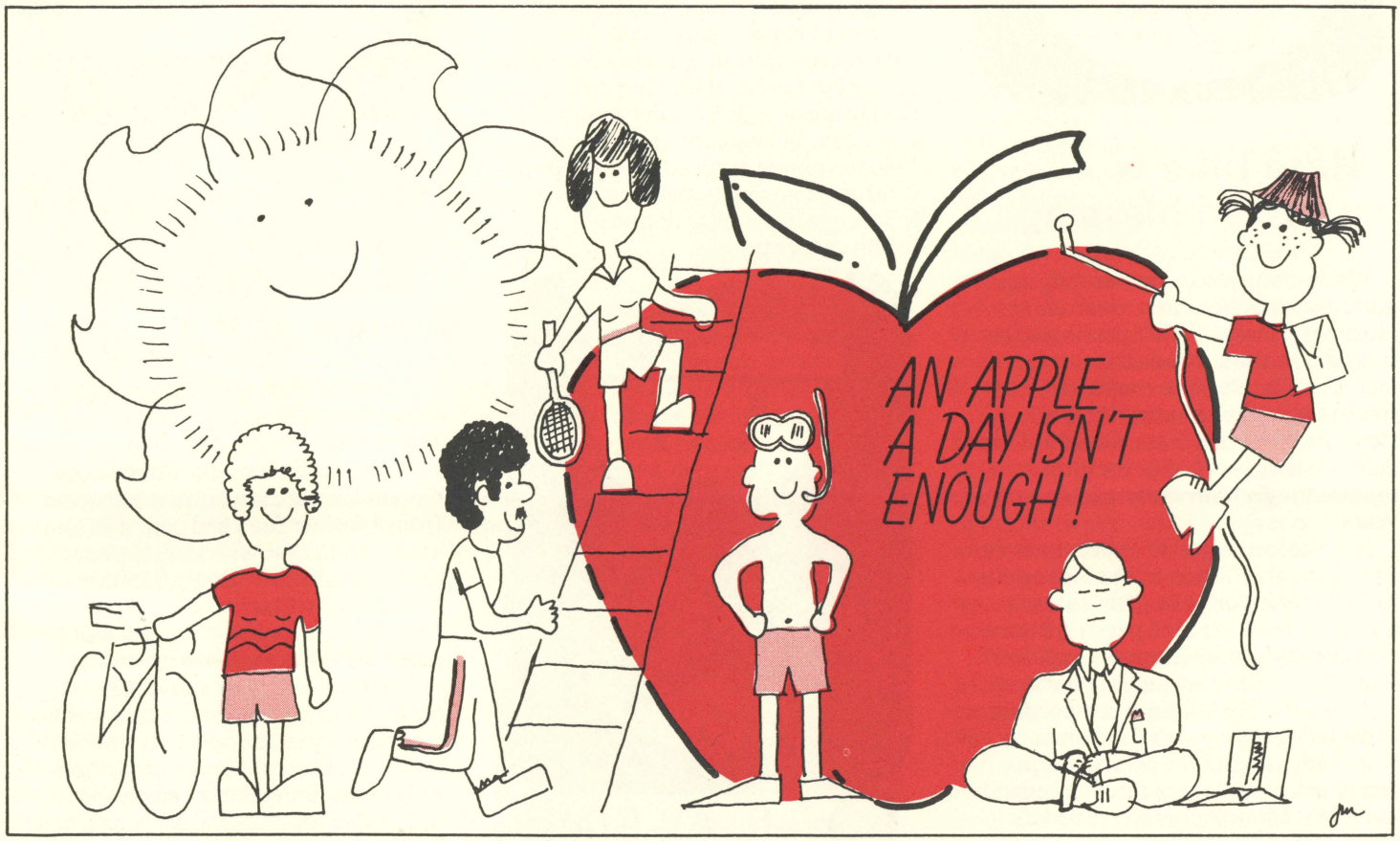


Come To The Good Health Carnival

9:30 a.m. to 6 p.m. Saturday, June 28, Vacaville Community Center

Intercommunity Hospital and about 25 health-related businesses, clubs and clinics will sponsor a Good Health Carnival for Upper Solano County on June 28.

Displays, booths, free samples, discount coupons, demonstrations and entertainment will contribute to the carnival mood from 9:30 a.m. to 6 p.m. on Saturday at the Vacaville Community Center.

"Going to the Carnival will be a way for adults to get a taste of all the ways we can get healthy, stay healthy and have a good time doing it," said ICH coordinators of the event Marilynn Harris and Nancy Tubbs.

"Summer is a good time to think about slimming down, and Carnival-goers can check out some of the local spas, weight reduction programs and diet clinics." said Mrs. Harris, hospital development coordinator.

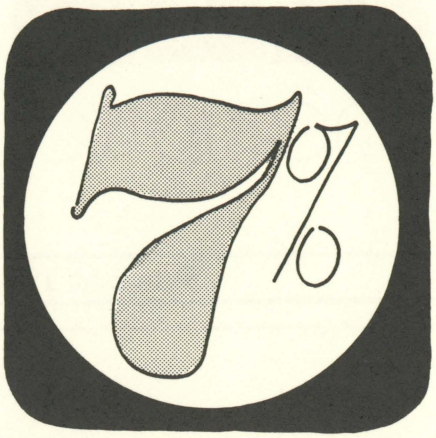
For the person who's resolved to get more exercise, there will be a chance to look into clubs and classes featuring racquetball, tennis, dancersize, karate, and more available in Vacaville and Fairfield. Instructors and students from local clubs will be on stage at the Community Center to show how it's done.

"We're inviting stress reduction and stop-smoking clinics, health food stores, sporting goods pros and wholistic health experts to show us their wares, programs and ideas," Ms. Tubbs said.

We're hoping to stimulate people who come to the carnival to make those kinds of healthy life style changes that are going to keep them trim, strong and energized, and keep them out of the hospital.

People who took the hospital-sponsored Health Hazard Appraisal in May will get their HHA results interpreted and have an opportunity to explore the Carnival too.

COMMENTARY



Rate hike is a mixed blessing

While many prices are shooting up quite dramatically, Intercommunity Hospital is pleased as it's possible to be these days to announce a room rate increase. The pleasure comes from the size of the rate hike, only 7%. It also stems from the fact that we were able to delay making the change for three months longer than we have in recent years.

It's nice in a period of approximately 14% annual inflation to be able to delay the inevitable and to keep the rate at a moderate level. At $166 per day, Intercommunity's room rate remains lower than that of other hospitals in our area.

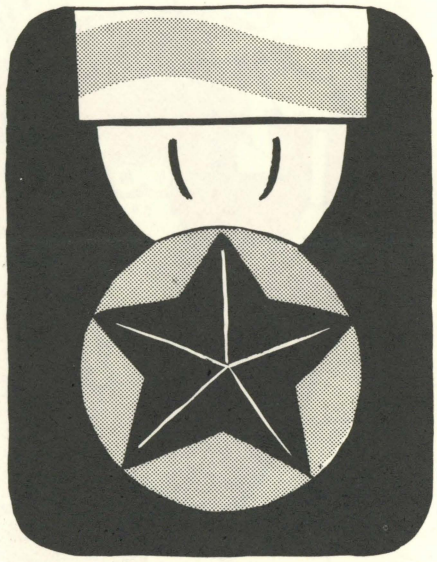
To put the 7% hike into perspective consider that last year's Consumer Price Index logged the percentage increase in hospital room rates nationwide at 11.2%. Intercommunity raised its room rates only 7% that year too, and the year before.

In May we began planning our first major rate revision at ICH in almost four years. This larger revision, affecting many areas of the hospital, is being undertaken very thoughtfully. Our goal is to bring our charges to patients into line with the 1980 costs for providing services. It will result in price hikes for various services and supplies, but may also result in some price reductions, as well.

While we attempt to keep all our charges at a reasonable level, we are faced, of course, with paying the same rising prices for goods and services as are other consumers.

A study by the National Center for Economic Alternatives cites a 17.6% increase in the cost of basic necessities for Americans during 1979. These include rises of 37.4% for energy, 17.4% for housing and 10.2% for food. During that time the inflation rate for all medical care was held to 10.1%

Intercommunity and hospitals nationwide can be proud of our success in significantly reducing inflation in the cost of medical care. At ICH we have successfully integrated the concept of cost containment into the basic management style by which we operate every day. We look forward during 1980 to another successful year helping California hospitals meet the Voluntary Effort goals to limit inflation of health care costs.

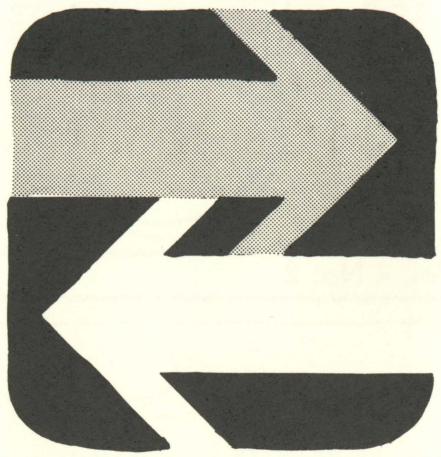


Hurrah, All-Stars!

U.S. hospitals celebrated National Hospital Week in May this year with a tip of the hat to the Health Team All-Stars.

Intercommunity can be tremendously proud of its team -- the staff, physicians, volunteers and the Board of Directors. We don't often recognize the important role played by each member, but the nationwide observance gave us a golden opportunity to say "You deserve a medal" to the folks who contribute such a tremendous effort at Intercommunity all year around.

Of course, excellence in providing hospital care has many daily rewards. Among the most lasting is the knowledge that we've done our best to provide the high quality care our patients need.



Ambulatory Surgery and Physical Therapy find homes at ICH

Intercommunity's new Ambulatory Surgery Center (ASC) and Physical Therapy Unit opened their doors side-by-side last month. The two new patient-care areas were reconstructed from a former four-bed pediatric unit after the children's services moved to the hospital's new wing in January.

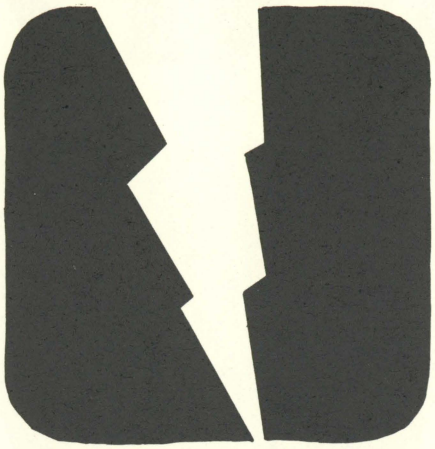
The ASC will serve patients who come to ICH for low-risk, one-day surgeries and go home the same day. In the past some of these short-stay patients were prepared for surgery and recovered from the operation in the hospital's Emergency Room. Others who were admitted to a bed on one of the Medical-Surgical Nursing Units for the day and paid an additional fee for the use of the patient room, may also be cared for in the ASC in the future.

The new facilities will allow more than the former 40 patients per month to take advantage of the less-expensive ambulatory surgery option. The Center can accomodate five or six patients per day.

Next door to the ASC is the newly equipped Physical Therapy Unit, staffed six days a week by Physical Therapist Barbara Kerrigan. Patient services here are provided under a contract service with Geraldine Morrison, RPT, A Professional Corporation.

The small area is fully equipped to help patients strengthen and regain use of their disabled limbs. The therapist provides gait training for patients with

broken legs and those recovering from surgery. Acute rehabilitation services are available for patients who have suffered serious trauma, from strokes for example, or who are recovering from neurological injuries.



ICH plans to zap energy costs

Everyone is aware of rising fuel costs. We see the evidence at the gas pump and on our monthly gas and electric bill. In 1979 Intercommunity paid nearly $125,000 for utilities. Over the next five years ICH administration estimates that our fuel consumption could jump 100 percent due to hospital expansion. With inflation and increased cost of electricity and and natural gas, utility bills could increase 300 to 400 percent. Unless the skyrocketing fuel costs are counteracted, ICH could face an astronomical annual energy bill of $600,000 in 1985.

With a combination of new technology and ingenuity, Hospital Engineer Ed Smith says "we hope to hold the fuel cost rise to 135 to 145 percent over the next five years. That will save millions."

Preliminary conservation measures are already in effect at ICH. For example, all fluorescent lighting has been changed from 40-watt tubes to 35-watts for a 15 percent energy savings. Likewise, the wattage used by incandescent fixtures has been reduced.

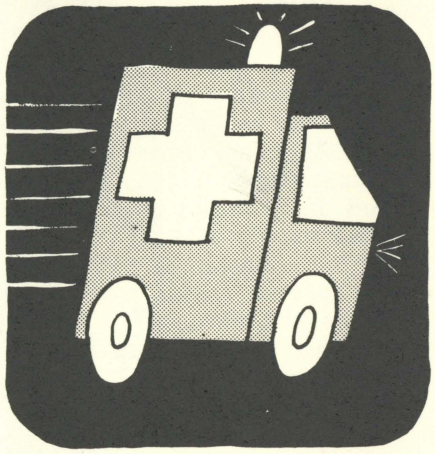
Now that we've reached a high level of efficiency, we're ready to start new, long-range projects. "We have about 20 energy-saving proposals on the drawing board," said Smith. The first step is to obtain federal and state funding available for energy conservation projects.

Results from a preliminary study by energy and technical auditors will be submitted to the California Energy Commission this month. The survey will include statistics to show funding agencies whether ICH's energy-saving projects are feasible. If federal matching-funds are approved, we will apply for low-interest state loans to help us get started.

"Any projects undertaken must pay for themselves within five years in order to be worthwhile," Smith said.

The first proposal recommends that ICH generate its own power during peak usage hours. Once this is accomplished, PG & E would pay Intercommunity 15-cents a kilowatt hour plus the cost of fuel for running its own emergency generator for eight to ten hours a day. The generator would supply power to all essential areas of the hospital.

Another plan on the drawing board would couple a heat-recovery system to the hospital incinerator to reclaim up to 80 percent of the heat lost into the atmosphere during normal trash disposal. "We could eliminate six boilers scattered around the hospital and reduce our fuel consumption by 30 percent," Smith said.



It's a train It's a plane It's a disaster drill

In May it was a passenger train derailment. In April it was a multiple plane crash into a Vacaville school play yard.

The two were county disaster drills which help Intercommunity Hospital prepare staff for the real multi-casualty events which stress hospitals and other facilities on an average of once every 45 days in Solano.

The mock passenger train derailment was a routine alert of the variety staged monthly by Solano County's Emergency Medical Services staff. Emergency Room staff at ICH checked with other departments to inventory supplies, blood, respirators and available beds. The ER physician and nurse estimated that ICH could handle 25 patients, 10 of them critical, with existing resources. At that point the drill was completed.

The April 23 plane crash was a massive training exercise involving Vacaville police, fire and other city agencies. Dozens of volunteers were coached to act as mock patients and distressed family members.

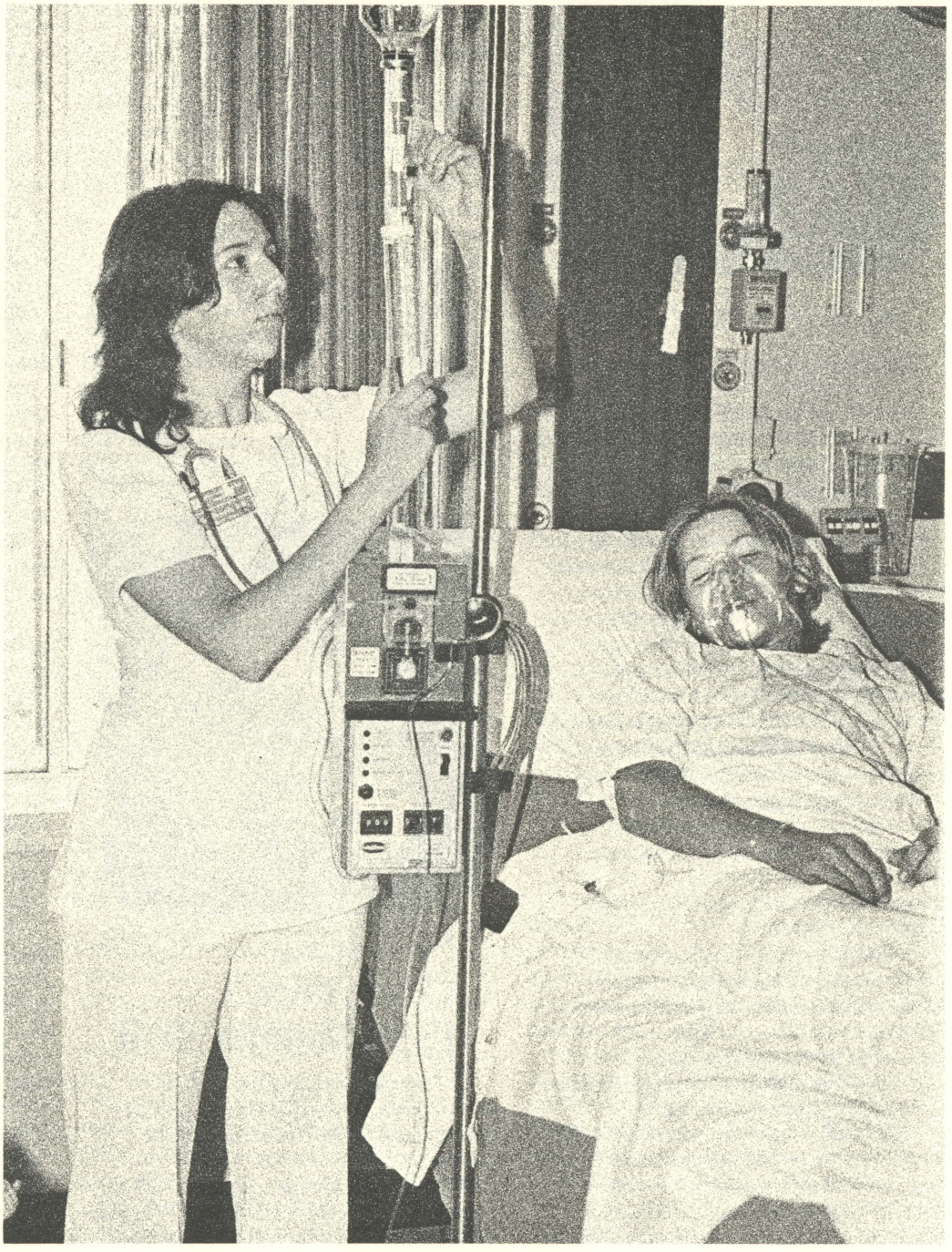
Intercommunity, which received twelve moulaged (made-up) patients by ambulance and helicopter, was stressed in nearly every hospital department. A new ICH team of patient transporters was assigned to bring patients from the ambulance to the treatment areas. This excellent crew was made up of housekeepers, Medical Records and Business Office staff.

For the first time during a drill the Family Information Center set up to support family and friends of victims, received callers and distressed parents of the mock patients. The parents were portrayed by senior citizens and high school drama students, and were comforted by hospital staff and volunteers.

The biggest surprise of the drill was a helicopter which landed in the hospital parking lot bearing what a phone call had informed us was a real patient who had stopped breathing. On a few moments notice the parking lot had to be prepared for the landing. Emergency Room physician Ross McCabe was ready to perform a trach on the patient as she was taken from the copter . . . and she was a drill victim after all.

There was no operation, but it was good to know that the quick response is there on everybody's part when we need it. The surprise landing also taught us that despite a number of other sucessful operations with helicopters, we may need to tighten up our safety and security procedures. Preparation of a special landing area is being considered for the future.

GRAND



Focus on patient care . . .

ROUNDS

The 11-year-old boy struggled to breathe as his worried parents and physician hurried him into Intercommunity's Pediatric Unit. "He looked awful coming down the hall," recalled the pediatric nurse on duty the evening the boy arrived. "He was pale and wheezing from a bronchial spasm caused by asthma. Every breath looked like his last. His chest would almost flatten to his spine with each breath because he was working so hard to draw air."

Peds nurse Gail Neasbitt vividly recalled for ICH's initial Nursing Grand Rounds meeting the case of a young asthmatic she called "Johnny" to preserve patient confidentiality.

"Grand Rounds is a meeting to learn from a specific case and exchange nursing care ideas," explained Staff Development Coordinator Sylvia Frietze. "Nursing care plans are developed for every patient, and team conference problem-solving sessions are held to deal with immediate problems. Grand Rounds takes the team conference idea several steps futher by incorporating all aspects influencing the patient's care."

"Each month one of the Nursing units -- Medical-Surgical, Maternity, Intensive Care or Pediatrics -- will present a case study of general interest to expand the knowledge of our Nursing staff."

"We chose Johnny's case for our first Grand Rounds to illustrate how children differ from adults in their response to treatment," said Pediatric Head Nurse Christi Landis. "It's important for staffs of other units to know this because when Peds is full, the older children are moved to the adult units."

As Mrs. Neasbitt described Johnny's case, she outlined his prior history of allergies to wheat, milk, chocolate, eggs and pollens. The combined effects of spring pollens, a viral cold and some laxity about avoiding the prohibited foods brought Johnny to the hospital when routine medication failed to calm the asthmatic reaction.

Laboratory tests showed that Johnny's system lacked oxygen. He was unable to expel excess carbon dioxide and was experiencing severe respiratory acidosis, a blood chemistry imbalance. "In an adult, the condition would be critical," noted Mrs. Neasbitt, "but Johnny was lucky that children can tolerate acidosis to a much higher degree."

"Every two hours during the first night Johnny suffered severe wheezing and difficulty breathing," continued Mrs. Neasbitt. "We watched Johnny for dehydration, checked his intravenous solution rate and monitored his vital signs for any hint of exhaustion, respiratory or cardiac arrest." His respiratory therapy treatments were stepped-up. "Johnny was very cooperative about taking medicated vapor treatments and coughing to break up lung congestion.

"To properly advise the physician, we constantly access the patient. In Johnny's case, I worried about exhaustion from prolonged respiratory distress. His breathing hadn't improved by morning, and respiratory failure was becoming a real threat."

Johnny's doctor and a pediatric specialist were consulted and it was decided to increase the boy's medication. In 24 hours his asthma was under control, and Johnny was discharged after a four-day stay.

"Prior to his departure, we went over Johnny's dietary restrictions and medications with his parents. His family was very receptive. We discussed psychological and social pressures that affect asthmatics and things to avoid such as sudden exertion, emotional stress and exposure to colds," Mrs. Neasbitt said.

"Judging from the types of questions about Johnny's diet and family background asked by Grand Rounds participants," said Mrs. Frietze, "I'd say that it was a good learning experience. In future presentations we'll bring in members of ancillary services who treated the patient. The pharmacist, for example, might discuss particular drugs used in the treatment.

"We hope to include the patient and family in Grand Rounds..."

—SYLVIA FRIETZE—

"In broadening the program in the future we also hope to include the patient and family in Grand Rounds discussions. We want to know how they experienced the hospital stay. What were their needs and did we meet them? How did they view the patient's treatments, education and discharge arrangements? Ideally, we will hold Grand Rounds before the patient is discharged so we can anticipate and plan more intensively for any problems that might arise during the remainder of the patient's stay. "These innovative Grand Rounds concepts will help our nurses to keep growing, learning, and most importantly to provide the very best nursing care possible for our patients."

WAITIN

with a little help from

WAITING . . . almost everybody hates it. Pacing up and down a waiting room outside a hospital emergency room door is definitely one of the worst kinds of waiting.

You impatiently check the clock, leaf through a 1942 National Geographic, lose a quarter in the soda machine, wonder what's keeping the doctor, stare out the window and test your finger again to see if it still feels broken. Ten minutes have passed, and you pace back up to the receptionist to ask one more time how long it will be before you are called.

Or you're waiting in shock to hear whether one of your parents is going to pull through the heart attack, or if a child has regained consciousness after an auto accident, or whether a friend will have to go to surgery.

Then, waiting is terrible. And so a dozen of Intercommunity's Guild volunteers have undergone special training to learn how to help people weather the stress of an Emergency Room visit.

During the Emergency Department's busiest hours these volunteers act as support people and advocates for patients and the people who come with them to the hospital.

They bring coffee, help make phone calls and facilitate communications between people in the waiting room and the patients and staff behind the Emergency Room door.

"We want people to know that we have time to spend with them," said Ann Fike, the volunteer coordinator of this small group. "They know that the staff needs to be in working with patients, but they can ask us to stay and talk with them."

In a new training program designed for the group by the hospital's educator Sylvia Frietze and Community Services Coordinator Nancy Tubbs, the volunteers became familiar with the concerns of Emergency Room visitors.

"Patients are often under a lot of stress when they come in, even when their problem is not an urgent one," said Ms. Tubbs. "The person whose life is in danger is rushed right into the ER and the doctor and nurses see him right away. But the one who's sitting out front with a broken finger on a busy night doesn't see anyone in a white coat at first. She's in pain. She's a little scared. Perhaps coming to the hospital makes her a bit more aware of her own mortality. Many people just feel anxious in a hospital setting."

The volunteer lets the patient know why she is waiting and what the medical staff is doing that prevents them from dealing with her problem right away. Perhaps four other cases came in just ahead of her or the entire staff is back there trying to get somebody breathing again.

While the patient is being seen, you may have one or more very anxious friends or family members pacing the waiting room carpet wondering what's happening and needing emotional support." Ms. Frietze said. "The patient's husband is thinking, 'Is it something serious? Should I have brought her in sooner? How are we going to pay for this?' A hundred fearful, guilty, angry, concerned thoughts are running through his head."

He may not want to talk to anybody, but if he does, the volunteer is there to listen, offer a cup of coffee and keep him posted on his wife's progress in the Emergency Room.

"Just having someone there who cares can make all the difference in the world."

—JEAN LUNOE—

G

a friend in the Guild

Part of a volunteer's training is to know when to get help too.

"The volunteers are really our eyes and ears in the Waiting Room," said ER Charge Nurse Bobbie Bourne. "If someone suddenly feels worse or begins to panic or starts harassing other people, the volunteer calls us right away."

They also provide staff with feedback on patient or family complaints. Such problems seem to loom larger by the minute if they are not dealt with quickly by staff.

One distraught man threatened to break every plate glass window in the Waiting Room if he didn't get attention immediately.

"I went for a nurse right away," related volunteer Jean Lunoe. "He was the husband of a woman who attempted suicide and wanted to know what was going on with his wife in the ER."

Another night Mrs. Lunoe comforted a grandmotherly woman with a badly broken leg. Mrs. Lunoe called the woman's son-in-law for her, brought coffee and accompanied her to Radiology.

"She was worried about whether her hair net was on straight, and would they take her false teeth out if she went to surgery. She sent me out to tell her husband that he'd better keep the house clean while she was in the hospital."

"She was 80 years old and worried about all the little things that come to mind while you're waiting. Just having someone there who has an ear to listen and who cares can make all the difference in the world, "Mrs. Lunoe said. "Otherwise an Emergency Room can be a very lonely place."

"For me this is the most rewarding volunteer work."

—ANN FIKE—

It's during the really busy times when the staff is tied up with a rush of patients that the people in the Waiting Room need the most reassurance, information and support. The staff can't get out there and may not be able to spend as much time as they would like giving emotional support to patients in the ER.

One frantic night a youngster with a severe head injury had to be prepared for helicopter transport amid a crush of other emergency patients. "One of the nurses had to fly out with the boy, and that left the ER short-staffed," said volunteer Lillian Loustau. "Boy did I do a lot of running that night!"

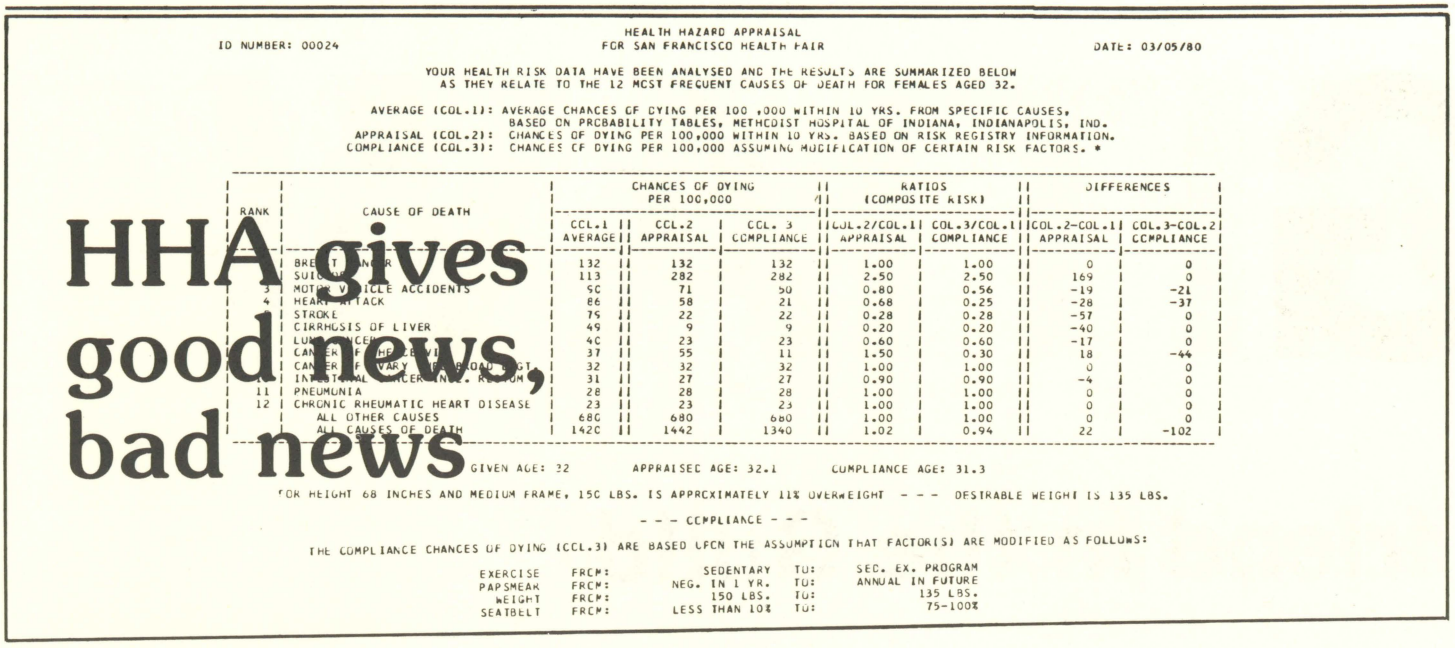
On another evening she sat patiently encouraging a three-year-old child to drink fluids so that the busy staff could get a urine sample from the youngster.

Each volunteer is on duty two nights a month from 6 p.m. to 9 p.m., among the Emergency Room's busiest hours. With the number of volunteers available, about 20 evenings a month are being covered. Since the training period ended the group has continued to meet to brush up on the skills needed for the job, among them tact, diplomacy and good communication techniques.

"Active listening is really a key to the volunteers' job," Ms. Tubbs said. "They're listening not only to the words that are being said, but to what's being communicated non-verbally by the person's tapping foot, slumped shoulders or white knuckles. When they meet someone telegraphing distressed feelings, basically they communicate back a willingness to hear what's wrong and to help."

"For me this is the most rewarding volunteer work," group leader Ann Fike said. "We're there to help somebody during a time that's really hard for them. And we're learning a lot at the same time."

HHA gives good news, bad news



HEALTH HAZARD APPRAISAL
FOR SAN FRANCISCO HEALTH FAIR

ID NUMBER: 00024 DATE: 03/05/80

YOUR HEALTH RISK DATA HAVE BEEN ANALYSED AND THE RESULTS ARE SUMMARIZED BELOW AS THEY RELATE TO THE 12 MOST FREQUENT CAUSES OF DEATH FOR FEMALES AGED 32.

AVERAGE (COL.1): AVERAGE CHANCES OF DYING PER 100,000 WITHIN 10 YRS. FROM SPECIFIC CAUSES, BASED ON PROBABILITY TABLES, METHODIST HOSPITAL OF INDIANA, INDIANAPOLIS, IND.
APPRAISAL (COL.2): CHANCES OF DYING PER 100,000 WITHIN 10 YRS. BASED ON RISK REGISTRY INFORMATION.
COMPLIANCE (COL.3): CHANCES OF DYING PER 100,000 ASSUMING MODIFICATION OF CERTAIN RISK FACTORS. *

RANK	CAUSE OF DEATH	CHANCES OF DYING PER 100,000			RATIOS (COMPOSITE RISK)		DIFFERENCES	
		COL.1 AVERAGE	COL.2 APPRAISAL	COL. 3 COMPLIANCE	COL.2/COL.1 APPRAISAL	COL.3/COL.1 COMPLIANCE	COL.2-COL.1 APPRAISAL	COL.3-COL.2 COMPLIANCE
1	BREAST CANCER	132	132	132	1.00	1.00	0	0
2	SUICIDE	113	282	282	2.50	2.50	169	0
3	MOTOR VEHICLE ACCIDENTS	90	71	50	0.80	0.56	-19	-21
4	HEART ATTACK	86	58	21	0.68	0.25	-28	-37
5	STROKE	79	22	22	0.28	0.28	-57	0
6	CIRRHOSIS OF LIVER	49	9	9	0.20	0.20	-40	0
7	LUNG CANCER	40	23	23	0.60	0.60	-17	0
8	CANCER [illegible]	37	55	11	1.50	0.30	18	-44
9	CANCER OVARY [illegible]	32	32	32	1.00	1.00	0	0
10	INTESTINAL CANCER [illegible]	31	27	27	0.90	0.90	-4	0
11	PNEUMONIA	28	28	28	1.00	1.00	0	0
12	CHRONIC RHEUMATIC HEART DISEASE	23	23	23	1.00	1.00	0	0
	ALL OTHER CAUSES	680	680	680	1.00	1.00	0	0
	ALL CAUSES OF DEATH	1420	1442	1340	1.02	0.94	22	-102

GIVEN AGE: 32 APPRAISED AGE: 32.1 COMPLIANCE AGE: 31.3

FOR HEIGHT 68 INCHES AND MEDIUM FRAME, 150 LBS. IS APPROXIMATELY 11% OVERWEIGHT - - - DESIRABLE WEIGHT IS 135 LBS.

- - - COMPLIANCE - - -

THE COMPLIANCE CHANCES OF DYING (COL.3) ARE BASED UPON THE ASSUMPTION THAT FACTOR(S) ARE MODIFIED AS FOLLOWS:

EXERCISE	FROM:	SEDENTARY	TO:	SEC. EX. PROGRAM
PAPSMEAR	FROM:	NEG. IN 1 YR.	TO:	ANNUAL IN FUTURE
WEIGHT	FROM:	150 LBS.	TO:	135 LBS.
SEATBELT	FROM:	LESS THAN 10%	TO:	75-100%

By Nancy Jo Tubbs
Community Services Coordinator

First the good news.

The odds tell me that I'm likely to survive the next 10 years. In fact, chances are I'll live to my full life expectancy, age 78 for women.

Just to be sure (and now the bad news) I should buckle up my seatbelt, take up something strenuous like jogging, get an annual pap smear and, here it comes, lose 15 pounds.

Both the good and bad news came in the mail recently when I got the results of the 42-question Health Hazard Appraisal I took at Health Fair '80 in May. The HHA form surveys a person's vital statistics, health history and life style. Put them all together, run them through the computer at the Center for Disease Control in Atlanta, and what comes back are the odds.

The odds of dying. More specifically, the computer told me my chances of dying from the dirty dozen -- the 12 most frequent causes of death for women my age during the next 10 years. At age 32 the first four on that hit parade are breast cancer, suicide, motor vehicle accidents and heart attack.

My first reaction to reading the cool, green computer print-out was "I'd rather be immortal." But the reason behind the Health Hazard Appraisal is to give people the chance to change the things they do that are liable to hurt them in the long run.

Ah, change. What a simple idea.

I write that with tongue in chubby cheek, because of course there have been diets. Years of diets with only 10 to 15 pounds to lose. And the pounds linger on and off and back on again. I finally said, "Forget it. The pounds cause me less problems than does the stress of worrying about them."

But the Appraisal says that overweight matters. For people 20 percent or more overweight, high blood pressure and cholesterol levels are a risk. Women in this category have an increased risk of developing cancer of the uterus and a slightly increased risk of breast cancer. Both men and women have less resistance to infections. I may decide to reexamine the idea of dieting after all.

I fared better with the Appraisal's admonition about motor vehicle acidents. I've never given much thought to wearing a seatbelt. But in the office where I work the phone rings many workday mornings with calls from the press folks getting updates on the latest auto accident victims brought into our busy Emergency Department. I'm here to tell you, there are a lot of fatalities, right out there on that patch of Interstate 80 that I (and probably you) drive 'most ever day.

I've started wearing a seatbelt. Within a week I was uncomfortable without it, sort of insecure like a child without her blanket and thumb. That was an easy change to make.

The pap smear is a breeze too. Heaven knows we can't prevent all cancer, but we can avoid some risks and opt for early detection and treatment.

What's left? Ah, exercise. During the summer that's not too hard. The pool is warm, and I swim. Weekend and early evening bike rides help me bring down my stress level after a busy work day too.

I'm looking forward to the Good Health Carnival on June 28 so that I can find some other fun ways to shake out my muscles, especially during the winter months when I tend to hibernate.

The computer gives HHA participants more information than their high risk factors and advice about the lifesyle changes we should make. It also reports our given age, our appraised age and our compliance age.

For example, imagine my real or given age is 51. If I were 60 pounds overweight and smoked two packs of cigarettes a day, my appraised age might be listed as 60. In other words, I'd have the same chances of dying as a 60-year-old.

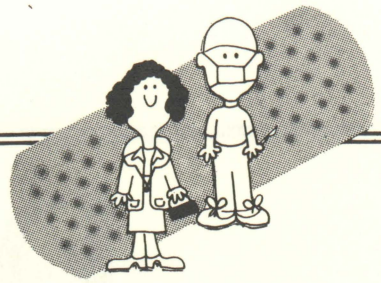
Something to think about.

But the computer also reports that my compliance age is 46-years. That means that if I comply with the computer's recommendations, I can lower my risks to that of a 46-year-old person. I could turn the clock back six years.

Would it be worth it to make the effort? It's a question we each have to ask ourselves.

Did you fill out a Health Hazard Appraisal? If so, get your interpretation between 9:30 and 6 p.m. Saturday, June 28, at the Vacaville Community Center during the Good Health Carnival.

LIFESAVERS



Getting a second opinion is a good way to operate

Every day we make decisions. Some are easy, like what to wear to work. Some are harder, like whether to buy a house. When you must make a difficult decision, it helps to know as much as possible about the pros and cons.

The same is true when a doctor advises you to have non-emergency surgery. There are risks with any surgery and you should know what these are. You should also know what the surgery will do and whether other medical treatment might be used instead of surgery.

When thinking about non-emergency surgery, one way you can help yourself to reach a decision is to seek the advice of another qualified doctor by getting a second opinion.

There are differences of opinion about medical problems. One doctor may recommend surgery; another may tell you to wait a while; another may suggest another kind of treatment. When you ask the right questions, receive thorough information, and have the opinions of two doctors, you increase your chances of making the decision that is right for you.

A second opinion *should not* be used to delay or avoid having an emergency operation. When there is time, a second opinion should give you additional information to help you decide if surgery is the best thing for you. You have every right to that information.

Questions you should ask

Before agreeing to any non-emergency surgery, you should know the answers to these questions:

1. What does the doctor say is the matter with you?
2. What is the operation the doctor plans to do?
3. What are the likely benefits to you of the operation?
4. What are risks of the surgery and how likely are they to occur?
5. How long would the recovery period be and what is involved?
6. What are the costs of the operation? Will your insurance cover all of those costs?
7. What will happen if you don't have the operation?
8. Are there other ways to treat your condition that could be tried first?

Ask these and any other questions you might have. The more you know, the better prepared you'll be to make a decision about surgery.

When should you get a second opinion?

Sometimes surgery is done on an emergency basis. It must be done right away, or within a few days, as in the case of acute appendicitis or injuries from an accident. *Because any delay could be life-threatening, second opinions are seldom possible for this kind of surgery.*

But much surgery is not an emergency. You have the time to choose when you want to have it, and even if you will have it. Some operations that are *usually* not emergencies are tonsillectomies, gall bladder operations, hysterectomies, hernia repairs and some cataract operations.

Anytime a doctor suggests non-emergency surgery, you should consider getting a second opinion.

- Make sure that a short delay will not be harmful.
- Make sure you have as much information as possible about the benefits and risks of the surgery.
- Find out if there are any other methods of treatment that you and your doctor can try first.
- Weigh the benefits and risks of having the operation against the benefits and risks of *not* having it.

Getting a second opinion is standard medical practice. Most doctors want their patients to be as informed as possible about their condition.

How to find a specialist to give you a second opinion

If your doctor recommends non-emergency surgery, there are several ways to find a surgeon or another specialist in the treatment of your medical problem:

1. Ask your doctor to give you the name of another doctor to see. Do not hesitate to ask; most physicians will encourage you to seek the second opinion.
2. If you would rather find another doctor on your own:
   - You can contact your local medical society at 642-9202 in Vallejo for the names of doctors who specialize in the field in which your illness falls.
   - If you're covered by Medicare or Medi-Cal you can call your local Social Security Office listed in your telephone directory under U.S. Government, Department Of Health, Education, and Welfare.

How to get a second opinion

Some people do not feel comfortable letting their doctor know that they are getting a second opinion. However, if you tell your doctor, you can ask that your records be sent to the second doctor. In this way, you may be able to avoid the time, costs and discomfort of having to repeat tests that have already been done.

When getting a second opinion, you should tell the second doctor:

- the name of the surgical procedure recommended, and
- any tests you know you have had.

If the second doctor disagrees with the first, most people find that they have the facts they need to make their own decision. If you are confused by different opinions, you may wish to go back to the first doctor to further discuss your case. Or you may wish to talk to a third physician.

How to pay for a second opinion

Many private insurance companies pay for second opinions. You can contact your health insurance representative for details.

Medicare and Medi-Cal will pay for the second opinion as they pay for other services.

Information for this column came from the U.S. Department of Health, Education and Welfare and was approved by Intercommunity Medical Staff Surgery Committee.

Donors really

Development Director Marilynn Harris accepted a sweet donation from Dixon Ridge 4-H members Jill Bertolero, Melissa Hernandez and Carol Bertolero. The club, made up of members ages 9 to 19, made 35 gingerbread houses to sell at the Dixon May Fair to benefit Intercommunity. The funds will be used to buy games and toys for children in the ICH Pediatric Unit.

make our day

They had two years to do it, but Intercommunity Hospital supporters took only five months to meet a $25,000 matching-funds challenge by the Anheuser-Busch Foundation. The Foundation pledged to match any amount up to $25,000 that donors gave to the development program by November of 1981.

The gifts of $5 and up were doubled by a whopping check presented by Fairfield Anheuser-Busch Plant Manager George Weston last month.

These donors contributions were received during the Spring of 1980:

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George Weston, Anheuser-Busch plant manager wrapped up a $25,000 fund drive with presentation of matching funds to ICH Administrator Terry Pitts and Development Coordinator Marilynn Harris.

JACK GLASHOFF
- Albert and Carol Guyan

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- Nursing Staff at Intercommunity Hospital

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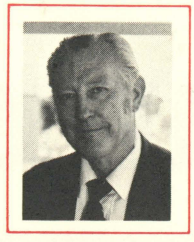
What's new and who's new

Physicians Take new Medical Staff officer spots



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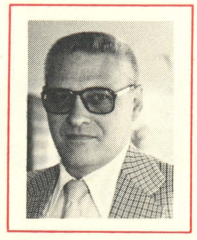
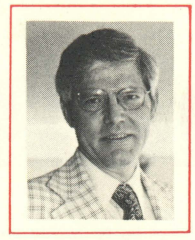


Lucas



Hill

Dr. Gerald Mahaffey, urologist and member of Ulatis Clinic, has succeeded Dr. Jose Chicarino-netto as Chief of the Medical Staff. Serving with him are Chief-Elect Dr. Richard Hill of Intercommunity Radiology Group and Secretary-Treasurer Dr. Richard Lucas, pathologist and director of the ICH Clinical Laboratory. They were installed during the March Medical Staff meeting.

The three medical staff officers served at David Grant Medical Center, Travis AFB, before joining Intercommunity. Dr. Mahaffey was Chief of Urology and the Outpatient Clinic at Travis prior to his retirement in 1971. His military service included 21 years as an Air Force physician following a tour of duty as a B-25 pilot during World War II. After the war he received his medical degree at the University of Washington in Seattle, followed by a residency at Letterman Army Hospital.

Drs. Lucas and Hill came to ICH in 1977. Dr. Lucas had been Chairman of Pathology at Travis for ten years, and Dr. Hill was Chief of Radiology for five years.

The Medical Staff officers have a challenging agenda ahead of them this year. Major projects include reorganization of committees, ratification of new bylaws and the establishment of a new quality assurance program.

Madeline Egolf is first 20-year retiree at ICH

They escorted her over a red carpet, out to her car which was filled with balloons. A dozen cans were strung to the back bumper. "Just Retired" read the sign taped to the car. And Madeline Egolf was.

Flowers, gifts and notes of congratulations had been arriving all week. About 100 friends and ICH employees gave her a "This Is Your Life" banquet, and her last Friday at the hospital was a circus. There was a special breakfast with her family, a singing telegram, a couple of clowns and dozens of visits from hospital staff.

Madeline, a registered nurse, was the first 20-year employee to retire from ICH, a hospital that is 20 years old itself. She came before the hospital opened its doors to set up Surgery, the Emergency and Obstetrics Departments, the Operating Room and Central Supply. She later served as Operating Room supervisor and purchasing agent until 1971 when she took the purchasing agent job full time.

Fondly called "Mother Intercommunity", Madeline told one newspaper reporter, I have very deep feelings about leaving. The hospital is almost like a child I've raised."

Now Madeline says she's looking forward to spending more time with her family and traveling with her husband, Harry.

"Madeline hasn't cut all ties with the hospital," noted Administrator Terry Pitts. Her house has been the center of picnic preparations for about eight years. She's still a Guild volunteer and an active member of the hospital Picnic Committee."

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House Call

House Call is published quarterly for the friends and employees of Intercommunity Hospital, 1800 Pennsylvania Ave., Fairfield, California. Address inquires to the Community Services Department.

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